STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155650	A. BUILDING 00 B. WING	09/08/2011

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LINCOLNSHIRE HEALTH CARE CENTER	8380 VIRGINIA ST MERRILLVILLE, IN46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for the Investigation of Complaint IN00095696 and IN00095938. Complaint IN00095696 substantiated, Federal/State deficiencies related to the allegations are cited at F 314, F 332, F 385 and F 501. Complaint IN00095938 substantiated, Federal/State Deficiencies related to the allegations are cited at F 314, F 332, F 385 and F 501. Survey dates: September 7 and 8, 2011 Facility number: 000577 Provider number: 155650 AIM number: 100266950 Survey team: Janelyn Kulik, RN Census bed type: SNF/NF: 85 Total: 85 Census payor type: Medicare: 21 Medicaid: 56 Other: 8 Total: 85 Sample: 11	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Supplemental sample: 2 These Deficiencies also reflect State findings cited in accordance with 410 IAC 16.2. Quality review completed 9/12/11 Cathy Emswiller RN			
F0314 SS=D	Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on record review and interview the facility failed to ensure residents received necessary treatment and services to promote healing for 1 of 3 residents reviewed with pressure ulcers in a sample of 11 related to not obtaining orders to restart nutritional supplements when the resident was readmitted to the facility. (Resident #G) Findings include: The record for Resident #G was reviewed on 9/7/11 at 1:30 p.m. The resident's diagnoses included, but were not limited to, decubitus ulcer to the right hip, sepsis, mental retardation, anxiety, knee	F0314	**F314** The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care. **1) Immediate actions taken for those residents identified:** The physician for Resident #G was contacted and orders were obtained to resume the multivitamin with mineral,	10/08/2011

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	contractures, atrial fibrillation, and gastroesophageal reflux disease. The resident was admitted to the facility on 7/12/11. An admission note dated 7/12/11 at 22:36 (10:36 p.m.), indicated a skin assessment was completed with a pressure area on the right hip measuring 6.5 cm (centimeters) by 5.5 cm by 0.2 cm. and a pressure area to the right ischial (buttock) measuring 0.4 cm by 0.4 cm. A pressure wound assessment dated 7/18/11, indicated a pressure area to the right hip measuring 7.3 cm by 6.1 cm by 0.3 cm. The area was a Stage III, indicated full thickness tissue loss. A progress note dated 7/20/11 at 16:21 (4:21 p.m.), indicated that was a dietary-nutritional risk assessment. The Dietitian recommended to provide diet per order, health shakes at lunch and supper, and change the Thera multivitamin to a multivitamin with minerals and add 30 ml (milliliters) of Promod (nutritional supplement) twice a day and 500 mg (milligrams) of Vitamin C twice a day for wound healing. A progress note dated 7/20/11 at 18:21 (6:21 p.m.), indicated the nurse spoke to the physician and related the dietary recommendations. A new order was		Promod and Vitamin C. **2) How the facility identified other residents:** An audit has been completed to identify any other residents re-admitted to the facility in the last 30 days with pressure sores to ensure that all nutritional interventions were resumed upon re-admission. **3) System in place:** Licensed Nurses will be re-educated on completing re-admission orders, including reviewing medications and nutritional interventions for wound healing ordered prior to hospital admission and notifying physician to obtain orders. Director of Nursing/Designee and Dietary Manager/Designee will review orders of all re-admissions and compare orders with previous orders to ensure nutritional interventions and medications for wound healing are continued as ordered by physician. The Dietician will provide the Director of Nursing/Designee a copy of all recommendations	

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	received and noted to change the Thera multivitamin to a multivitamin with minerals, 500 mg of Vitamin C twice a day, 30 ml of Promod twice a day with med pass and health shake at lunch and supper. A wound assessment dated 8/8/11, indicated the resident had a Stage III to the right hip measuring 6.0 cm by 4.2 cm by 1.2 cm. There was a Stage II (partial thickness loss of dermis presenting as a shallow open ulcer with a red pink ulcer bed) measuring 3.0 cm by 2.0 cm by 0.3 cm to the right ischial (buttock). There was excoriation to the left ischial area. The wound was improving and there were two new superficial areas noted to the ischial regions. A physician order dated 8/8/11, indicated to send the resident to the emergency room for evaluation and treatment. An admission note dated 8/11/11 at 19:30 (7:30 p.m.) indicated the resident had a pressure area to the right hip measuring 6 cm by 5 cm that was a Stage III. The right ischial, penis and scrotum were excoriated. A progress note dated 8/11/11 at 19:30 (7:30 p.m.), indicated the resident was readmitted to the facility. The resident had		given to nursing to ensure appropriate follow-up. The Wound Nurse will also be given a copy of all recommendations related to residents with wounds. The Dietary Manager/Designee will follow-up with nursing managers and the Director of Nursing/Designee after recommendations are made to ensure that recommendations were received and implemented. The Dietary Manager/Designee will ensure that recommendations are completed timely and documentation of current nutritional wound healing interventions is accurate. The results of these audits will be forwarded to the Quality Assurance Committee for review and any concerns will be addressed. **4) How the corrective actions will be monitored:** The Director of Nursing/Designee will be responsible for the coordination and monitoring of audits. The Director of Nursing/Designee will present the results of the audits to the Quality Assurance Committee	

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	a Stage III pressure area to his right hip. It was cleansed and covered with a dry dressing. The physician was notified and indicated to follow hospital orders. A wound assessment dated 8/29/11, indicated the right hip wound measured 3.9 cm by 2.4 cm by 1.5 cm. The right ischial measured 3.0 cm by 2.0 cm by 1.2 cm. There was excoriation to the left ischial area. The wounds were improving with more granulation tissue present. A progress note dated 9/2/11 at 16:58 (4:58 p.m.), indicated dietary progress note. The resident received Tab-a -vite to aid in healing but may better benefit from a multivitamin with minerals, 30 ml Promod twice a day and 500 mg Vitamin C twice a day for increased healing ability. The right hip wound had decreased in length and width since last evaluation but had increased in depth. Review of the August 11, 2011 and the September 2011 Physician Order Statement, indicated the resident did not have an order for the multivitamin with mineral, 30 ml of Promod twice a day and 500 mg of Vitamin C twice a day. Review of the August 11, 2011 and September 2011 Medication Administration Record, indicated the		monthly. **5. Date of compliance:** 10/8/11	

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	resident had not been receiving a multivitamin with minerals, 30 ml Promod twice a day and 500 mg Vitamin C twice a day since he was readmitted from the hospital on 8/11/11. The Nurse Consultant provided the Nutritional Assessment of Residents Policy and Procedure on 9/8/11 at 4:15 p.m. The purpose of the policy was "To define the policy and procedure for the assessment of resident's nutritional status." The Clinical Dietitian will perform a nutritional status assessment for all newly admitted residents. The Clinical Dietitian will then perform a nutritional assessment within 14 days of admittance according to the following guidelines. The guidelines included, but was not limited to, all nutritional history information pertinent to the resident's diet/condition will be documented. Interview with the Director of Nursing on 9/8/11 at 9:35 a.m., indicated the resident's physician should have been contacted to restart the multivitamin with minerals, Promod, and the Vitamin C. She indicated a new dietary recommendation had been made on 9/2/11 and put on the A Hall Unit Manager's Desk. The A Hall Unit Manager had left and was on vacation and had been called into work on 9/7/11 when she found the			

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	recommendation on her desk. She further indicated if the A Hall Unit Manager had not been called in the Dietary Manager would have informed her on 9/7/11 of the recommendation. Interview with the Director of Nursing on 9/8/11 at 9:40 a.m., indicated the resident had not been on those supplements in the hospital and did not return with an order for the supplements. She further indicated the staff had not inquired if the physician wanted to restart the supplements. Interview with the Nurse Consultant on 9/8/11 at 4:14 p.m., indicated the policy for nutritional assessment was for new residents not residents who were being readmitted to the facility. There was no policy for residents who were readmitted. This federal tag relates to complaint IN00095696 and IN00095938. 3.1-40(a)(2)			
F0332 SS=D	The facility must ensure that it is free of medication error rates of five percent or greater. Based on observation, record review and interview, the facility failed to remain free of medications error rate of 5 percent or greater related to giving medications after a meal when pharmacy recommended on	F0332	**F332** The filing of this plan of correction does not constitute an admission that the alleged	10/08/2011

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	an empty stomach and failing to give ordered medication for 1 of 11 sampled residents (Resident #D) and for 2 residents in the supplemental sample of 2 (Residents #N and Resident #O) during the observation of 3 of 4 medication administration passes. A total of 43 opportunities for error were observed. A total of 3 medication errors were observed. This resulted in a medication error rate of 6%. FINDINGS INCLUDED: 1. On 9/8/11 at 5:30 a.m. LPN #2 was observed preparing medications for Resident #N. The LPN placed one Levothyroxine (medication used to treat hypothyroidism) 50 mcg (micrograms) in a medication cup. There were no other medications in the medication cup. She then poured 10 ml (milliliters) of Carafate 1 g (gram)/ml (used to form a protective coating on ulcers) into a separate medication cup. She put applesauce in the cup with the Levothyroxine medications and poured a glass of water. At 5:35 a.m. the LPN entered the resident's room and administered the two medications. The record for Resident #N was reviewed on 9/8/11 at 5:40 a.m. The Physician Order Statement dated September 2011,		deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care. **1) Immediate actions taken for those residents identified:** As stated in the 2567, the medication Gemfibrozil for Resident #N was administered. However, please note that the medication was administered at 6:00 AM, not 6:00PM as stated in 2567. As stated in the 2567, the physician for Resident #O was notified, and an order was obtained to change the administration time of the Synthroid to 6:00 AM. As stated in the 2567, the Potassium Chloride was administered to Resident #D at 9:55 AM. **2) How the facility identified other residents:** An audit was completed of all residents receiving Synthroid to determine if any other residents were affected and no other	

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	indicated the resident was to receive Gemfibrozil (medication used to treat hyperlipidemia) 600 mg (milligrams) twice a day before meals at 6:00 a.m. and 1600 (4:00 p.m.). Review of the Medication Administration Record at 5:45 a.m., indicated the Gemfibrozil had been signed out as given on 9/8/11 at 6:00 p.m. Interview with the A Hall Unit Manager and LPN #1 at 6:00 p.m., indicated she had not given the resident the medication and was going to give her the medication at this time. 2. On 9/8/11 at 9:31:a.m. LPN #1 was observed preparing medications for Resident #O. The LPN placed one Synthroid (medication used to treat hypothyroidism) 25 mcg (micrograms), one Lisinopril/HCTZ (medication used to treat hypertension) 10/12.5 mg, and one Thera-M tablet in a medication cup. She then added applesauce to the medication cup. The LPN poured a glassed of water and entered the resident's room at 9:35 a.m. and administered the medications. Interview with LPN #1 and Resident #O at this time indicated the resident had eaten breakfast.		residents were identified. **3) System in place:** Licensed Nurses and QMA's will be re-educated on medication administration procedure, following manufacturer recommendations, and commonly used medications requiring administration prior to meals. The Director of Nursing/Designee will observe medication administration on varied shifts and provide further education. Any issues identified will be addressed upon observation. The Director of Nursing/Designee will conduct these observations until all nurses and QMA's have been observed. The Director of Nursing/Designee will review new orders during scheduled morning meetings 5 days per week to ensure that medications requiring administration prior to meals are scheduled at the appropriate times. The consultant pharmacist will audit all resident's medication regimens monthly. Any recommendations will be forwarded to the Director of	

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	Review of the label on the medication card for the Synthroid 25 mcg, indicated one daily. A pharmacy sticker on the medication card indicated to be given on an empty stomach. The record for Resident #O was reviewed on 9/8/11 at 12:15 p.m. The Physician Order Statement for September 2011, indicated Synthroid 25 mcg one tablet orally once a day, to be given at 9:00 a.m. Interview with the B Hall Unit Manager on 9/8/11 at 10:00 a.m., indicated most of the medications that were to be given on an empty stomach were scheduled at an earlier time than 9:00 a.m. Interview with LPN #1 on 9/8/11 at 10:30 a.m., indicated she had called the physician and obtained an order to change the administration time of the Synthroid to before breakfast. 3. On 9/8/11 at 9:50 a.m. QMA #1 was observed preparing medications for Resident #D. The QMA placed one Namenda (medication used for dementia) 10 mg (milligrams) in an medication cup. There were no other medications in the medication cup. She poured 60 ml (milliliters of Glucerna 2 Cal into a cup and poured a cup of water. At 9:55 a.m. she was administered the medication.		Nursing/Designee for appropriate action. **4) How the corrective actions will be monitored:** The Director of Nursing/Designee will be responsible for the coordination of the consulting pharmacist's recommendations for appropriate action. A summary of the pharmacist's audits will be presented at the Quality Assurance Committee monthly. **5. Date of compliance:** 10/8/11	

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	On 9/8/11 at 10:45 a.m. the Record for Resident #D was reviewed and the Physician Order Statement for September 2011, indicated the resident was to receive KCl (potassium chloride) 20 meq (milliequivalents)/15 ml (milliliters) 15 ml daily. Interview with the A Hall Unit Manager on 9/8/11 at 10:47 a.m., indicated the QMA should have given the resident the potassium chloride and she would administer the medication at this time. The Federal tag relates to Complaint IN00095696 and IN00095938. 3.1-25(b)(9) 3.1-48(c)(10)			
F0385 SS=D	A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician. The facility must ensure that the medical care of each resident is supervised by a physician; and another physician supervises the medical care of residents when their attending physician is unavailable. Based on record review and interview, the facility failed to ensure a resident's personal physician responded timely after multiple attempts were made to contact	F0385	**F385** The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided	10/08/2011

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	the physician related to a critically high potassium level for 1 of 5 residents reviewed for change in condition in the sample of 11. (Resident #J, Physician #1 and Medical Director) Findings included: The record for Resident #J was reviewed on 9/8/11 at 6:00 a.m. The resident's diagnoses included, but was not limited to, open abdominal wound, hypokalemia, end stage renal disease, esophageal reflux, pneumonia, urinary tract infection, anemia, malnutrition, and hypertension. A lab test result dated 8/5/11, indicated a potassium level of 2.6. The reference range was 3.5 to 5.3. The lab test indicated the results were "critical result called and read back: (name) 1324 (1:24 p.m.)". At the top of the lab result was the faxed date of 8/5/11 with a time of 14:39 (2:39 p.m.). The bottom of the lab result indicated left two messages with (Physician #1) answering (sic), no response. (Medical Director's name) called, no response. Director of Nursing notified and indicated to send the resident to the emergency room, 8/6/11. A progress note dated 8/5/11 at 14:56 (2:56 p.m.), indicated Spoke with Physician #1 concerning resident, new		as evidence of the facility's desire to comply with the regulations and to continue to provide quality care. **1) Immediate actions taken for those residents identified:** As stated in the 2567, Resident #J was sent to the hospital on 8/6/11. **2) How the facility identified other residents:** No other residents had a critical lab result on 8/5/11. **3) System in place:** Licensed staff will be re-educated regarding physician notification and alternate physician notification if the primary physician is unavailable or does not respond in a timely manner. Staff will be educated to notify the physician and if a response is not received in a timely manner the resident will be sent to the emergency room if the resident's condition is determined to be unstable. Lab results will be reviewed in morning meeting to ensure prompt physician notification. **4) How the corrective actions will be monitored:** Any issues with physicians not returning calls in a timely manner will be discussed with the Medical Director during the monthly Quality Assurance Committee meeting for him to address with his peers. **5) Date of compliance:** 10/8/11	

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	order received to discontinue foley catheter and foley catheter care, basic metabolic panel (blood test), PT/INR (prothrombin time/International normalized ratio time blood test for clotting), electrolytes, albumin, complete blood count, with differential bi-weekly, make appointment with (Physician #2's name). Resident's wife notified. At 17:00 (5:00 p.m.) Physician #1 was phoned and a message was left on voice mail for a return call to be updated on lab values. At 17:15 (5:15 p.m.) the lab results were received and Physician #1 was called and a message was left on voice mail for a return call to be updated on lab values. At 21:00 (9:00 p.m.) Physician #1 was phoned and a message was left on voice mail for a return call to be updated on lab values. A progress note dated 8/6/11 at 17:51 (5:51 p.m.), indicated the resident was in bed, alert and responsive. The resident had a critical lab but is asymptomatic at this time, will continue to monitor. Vital signs were blood pressure-114/68, temperature-97.5, pulse 72, and respirations were 16. Physician #1 was called and left two messages with the answering service. Physician #1 had yet to respond. Staff attempted to call the Medical Director and was unsuccessful as well. The Director of Nursing was			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	notified and indicated to send the resident to the hospital. The resident's wife was informed. At 18:46 (6:46 p.m.) the ambulance was at the facility to transport the resident to the hospital. The resident was alert and responsive. There was no distress noted at this time. At 19:30 (7:30 p.m.) the Medial Director returned the call related to the critical lab and was made aware of the resident being sent out to the hospital. At 21:30 (9:30 p.m.) Physician #1 returned call related to the resident's critical labs and was made aware the resident was sent to the hospital. The Nurse Consultant provided the Administrative Physician Notification for Change in Condition Policy on 9/8/11 at 4:20 p.m. The policy indicated, "The following symptoms, signs and laboratory values should prompt immediate notification of the physician. Immediate implies that the physician should be notified as soon as possible, either directly or by beeper/pager. If you do not obtain a response from the physician, call the designated alternate physician. If you still do not receive a response, notify the Director of Nursing for further instruction." Laboratory results: Potassium under 3.0. Interview with the Nurse consultant on 9/8/11 at 4:25 p.m., indicated the staff did			

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	155650	A. BUILDING 00 B. WING	09/08/2011

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	what they policy indicated the called the physician, Medical Director, and the Director of Nursing. The policy does not indicated what immediately means. She then indicated the staff did what they were to do in regards to the policy. This federal tag relates to complaint IN00095696 and IN00095938. 3.1-22(b)(2)			
F0501 SS=D	The facility must designate a physician to serve as medical director. The medical director is responsible for implementation of resident care policies; and the coordination of medical care in the facility. Based on record review and interview, the facility failed to ensure the Medical Director coordinated medical care for 1 of 5 residents reviewed for change in condition in the sample of 11 related to not responding when the facility could not reach the resident's physician for a critical lab value. (Resident #J, Physician #1 and Medical Director) Findings included: The record for Resident #J was reviewed on 9/8/11 at 6:00 a.m. The resident's diagnoses included, but was not limited	F0501	**F501** The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care. **1) Immediate actions taken for those residents identified:** As stated in the 2567, Resident #J was sent to the hospital on 8/6/11. The Administrator met with the Medical Director and instructed him on his responsibilities. **2) How other residents having**	10/08/2011

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	to, open abdominal wound, hypokalemia, end stage renal disease, esophageal reflux, pneumonia, urinary tract infection, anemia, malnutrition, and hypertension. A lab test result dated 8/5/11, indicated a potassium level of 2.6. The reference range was 3.5 to 5.3. The lab test indicated the results were "critical result called and read back: (name) 1324 (1:24 p.m.)". At the top of the lab result was the faxed date of 8/5/11 with a time of 14:39 (2:39 p.m.). The bottom of the lab result indicated left two messages with (Physician #1) answering (sic), no response. (Medical Director's name) called, no response. Director of Nursing notified and indicated to send the resident to the emergency room, 8/6/11. A progress note dated 8/5/11 at 14:56 (2:56 p.m.), indicated Spoke with Physician #1 concerning resident, new order received to discontinue foley catheter and foley catheter care, basic metabolic panel (blood test), PT/INR (prothrombin time/International normalized ratio time blood test for clotting), electrolytes, albumin, complete blood count, with differential bi-weekly, make appointment with (Physician #2's name). Resident's wife notified. At 17:00 (5:00 p.m.) Physician #1 was phoned and a message was left on voice mail for a		**the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken:** No other residents had a critical lab result on 8/5/11. **3) What Measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Licensed staff will be re-educated regarding physician notification and alternate physician notification if the primary physician is unavailable or does not respond in a timely manner. Staff will be educated to notify the physician and if a response is not received in a timely manner the resident will be sent to the emergency room if the resident's condition is determined to be unstable. Lab results will be reviewed in morning meeting to ensure prompt physician notification. **4) How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Any issues with physicians not returning calls in a timely manner will be discussed with the Medical Director during the Quality Assurance Committee meeting for him to address with his peers. **5) Date of compliance:** 10/8/11	

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	return call to be updated on lab values. At 17:15 (5:15 p.m.) the lab results were received and Physician #1 was called and a message was left on voice mail for a return call to be updated on lab values. At 21:00 (9:00 p.m.) Physician #1 was phoned and a message was left on voice mail for a return call to be updated on lab values. A progress note dated 8/6/11 at 17:51 (5:51 p.m.), indicated the resident was in bed, alert and responsive. The resident had a critical lab but is asymptomatic at this time, will continue to monitor. Vital signs were blood pressure-114/68, temperature-97.5, pulse 72, and respirations were 16. Physician #1 was called and left two messages with the answering service. Physician #1 had yet to respond. Staff attempted to call the Medical Director and was unsuccessful as well. The Director of Nursing was notified and indicated to send the resident to the hospital. The resident's wife was informed. At 18:46 (6:46 p.m.) the ambulance was at the facility to transport the resident to the hospital. The resident was alert and responsive. There was no distress noted at this time. At 19:30 (7:30 p.m.) the Medial Director returned the call related to the critical lab and was made aware of the resident being sent out to the hospital. At 21:30 (9:30 p.m.) Physician			

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	#1 returned call related to the resident's critical labs and was made aware the resident was sent to the hospital. The Nurse Consultant provided the Administrative Physician Notification for Change in Condition Policy on 9/8/11 at 4:20 p.m. The policy indicated, "The following symptoms, signs and laboratory values should prompt immediate notification of the physician. Immediate implies that the physician should be notified as soon as possible, either directly or by beeper/pager. If you do not obtain a response from the physician, call the designated alternate physician. If you still do not receive a response, notify the Director of Nursing for further instruction." Laboratory results: Potassium under 3.0. Interview with the Nurse consultant on 9/8/11 at 4:25 p.m., indicated the staff did what they policy indicated the called the physician, Medical Director, and the Director of Nursing. The policy does not indicated what immediately means. She then indicated the staff did what they were to do in regards to the policy. This federal tag relates to complaint IN00095696 and IN00095938. 3.1-13(v)(5)			

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